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AUTHOR Pearman, William A.
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ABSTRACT

This paper traces the development of the regionalization of health care services to the present model of the Health Systems Agency, HSA. Survey data obtained by a mailed questionnaire sent to hospital administrators is presented. The focus of the presentation is on a number of organizational variables as they influence the hospital administrator's perception of the necessity and effectiveness of the HSA. Organizational variables examined include the profit-nonprofit dimension; the location of the hospital, urban versus rural; organizational size as measured by three different criteria; and organizational age. Fifty questionnaires were mailed. Twenty-six questionnaires were returned, yielding a response rate of 52%. The findings are viewed as largely exploratory. Support for the HSA model among hospital administrators does not appear to be enthusiastic. Among those administrators who viewed the HSA as necessary, the model response was that the HSA's would be somewhat beneficial. Of all the variables examined, age of hospital seemed to be the most crucial in predicting support of the HSA. (Author/AM)

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ORGANIZATIONAL VARIABLES IN THE REGIONALIZATION OF HEALTH CARE

William A. Pearman
Professor, Sociology
Millersville State College

UD017306

ABSTRACT

ORGANIZATIONAL VARIABLES IN THE REGIONALIZATION OF HEALTH CARE

This paper traces the development of the regionalization of health care services to the present model of the Health Systems Agency, HSA.. Survey data obtained via a mailed questionnaire sent to hospital administrators is presented. The focus of the presentation is on a number of organizational variables as they influence the hospital administrator's perception of the necessity and effectiveness of the HSA. Organizational variables examined include the profit-nonprofit dimension; the location of the hospital, urban versus rural; organizational size as measured by three different criteria; and organizational age. Hypothesis on relationship are suggested even though the paper represents largely preliminary and exploratory findings.

Problem and Background

As we move into the latter quarter of the twentieth century, it becomes increasingly apparent that the federal government cannot possibly attend to all the funding demands which are being made of it. It is also apparent that in a society as complex as ours, one can find criss crossing networks of service delivery systems fraught with duplication and sometimes operating at cross purposes. Increasingly, we hear calls for reform in government, in welfare, in education and in various societal institutional systems. One form that response for reform has taken is to attack the problems on a regional level.

This paper examines the move toward regionalization of service delivery systems in one specific institutional area, namely that of health. It is quite obvious that even with our no-growth or low-growth economic system, the health field is a sector of stable or even increased growth. Specifically, the paper focuses on organizational variables as they affect perception of Health System Agencies, HSA. The HSA is a regional health mechanism developed under Public Law 93-641 and Section 1122 of the Social Security Act. Early reactions to this law were mixed. Some hospital administrators viewed the HSA in a very positive way, others had mixed feelings, while others launched open attacks in the public press. In this paper, we examine hospitals and their chief executives' views according to a number of traditional organizational characteristics such as: organization size (both staff size and bed size), location

(urban versus rural), the profit-nonprofit dimension, the age of the hospital, their degree of federal funding, etc.

It is planned that approximately 210 HSAs will be established in the 50 states. A large number are already in operation; some having been carved out of existing Regional Medical Programs, RMP, others are being shaped through health professional-citizen efforts without roots in predecessor organizations. The intent of Congress in establishing the HSA was to combine comprehensive Health Planning Agencies (CHP), the RMP, and the various Hill-Burton agencies. The purposes of the CHP were to inventory shortages and surpluses in health professionals, services and facilities in a given geographic area. and to review applications for federal funds in that area. The RMP was a development agency as opposed to the planning role of the CHP. They were designed to implement regional programs based on need identified by the CHPs. The Hill-Burton agencies concentrate on facilities construction. They assessed need for new facilities and provided hospital and other construction funds.

Public Law 3-641[(1)] charges HSAs with the following: 1) the improvement of health of the residents of their area, 2) making health care more accessible to area residents and improved in quality, 3) to hold down costs of health care, 4) to prevent duplication of health services when not warranted. A significant aspect of P.L. 93-641 is emphasis on local involvement, particularly health consumers. Consumers as well as providers of health services work together to determine local HSA

policies. Local plans and proposals are channeled up from the local level through state agencies for federal approval. If the proposals are approved on the federal level, the Department of Health, Education, and Welfare provides funds through grants to the state agency and the local HSA. Clearly, there is a threat to professional autonomy involved. Citizens-consumers are determining the course of development for health delivery in their local areas.(2)

Methodology and Findings

The results reported in this paper were obtained through a mailed questionnaire survey directed to hospital administrators. Hospitals were selected on a geographic basis from a list of member institutions of the American Hospital Association. The selection criterion was location in an eight county area of South Eastern and Central Pennsylvania near the researcher's home base. Fifty questionnaires were mailed. To date, twenty-six questionnaires have been returned for a response rate of 52%. The research presented here is viewed as largely exploratory.

Respondents were asked, "Do you feel that regional Health Systems Agencies are necessary or not necessary?" 57.7% of the respondents replied 'necessary', 30.8% replied 'not necessary' and 11.5% replied that they were undecided. Generally, the latter group indicated that the HSAs were too new to evaluate. Many of those responding negatively wrote in the questionnaire margin that they saw the HSAs as another bureaucratic hurdle or added red tape. The course of resistance, however, remains

largely unexplored.

Support for the HSA model among hsopital administrators does not appear to be enthusiastic. Of course, the HSA does represent a threat to their institutional autonomy in that an exterior group is called upon to approve their expansion plans and can set limits to their growth.

The remainder of this paper deals with an analysis of support for the HSA in terms of a number of sociological and organizational variables.

The classical point of departure for sociological investigation on complex organizations can, of course, be found in the writings of Max Weber.(3) Weber's conceptualization of bureaucracy emphasized the rational orientation of complex organizations. His distinction between formal and substantive rationality provides a basis for analysis of organizations according to the dimension of profit-nonprofit.(4) Weber viewed money as the most rational means of orienting economic activity and accounting in terms of money as the specific means of rational economic provision. Assessing action on the economic criterion of money or accounting he labeled as formal rationality. Substantive rationality allows for the fact that economic activity can be oriented to ultimate ends such as social goods.

Some sociological organizational classification systems do contain indirect reference to this dimension, e.g. Blau and Scott's classification of organizations on the basis of Cui Bono "Who benefits",(5) Parson's AGIL system based on organizational goals and societal needs,(6) or Etzioni's distinction between

utilitarian, normative and coercive organizations.[7] William Rushing[8] in his study of the relationship between differentiation and coordination in small general hospitals singled out the profit-nonprofit dimension for further empirical attention.

Unfortunately, in a small sample of hospitals, such as the one utilized here, a sufficient number of profit oriented hospitals does not exist. Nevertheless those profit hospitals which replied to the survey did feel more positive about the necessity of HSAs than did respondents from nonprofit oriented hospitals. 75% of the profit oriented hospitals felt that HSAs were necessary as opposed to 55% of the nonprofit oriented. Sample size precludes subjecting these figures to rigorous statistical inspection. One can only conclude that indeed this dimension may be important and warrants more detailed investigation. Profit hospitals may however view the HSA as a mechanism of potential value in increasing their profit or cash in-flow or as a mechanism placing them on more competitive footing with nonprofit hospitals. If the HSA is to act as a watchdog to prevent duplication of expensive services, the profit hospitals may see potential benefits in that nonprofit hospitals may be prevented from duplicating their service. This, of course, is pure conjecture.

Another variable examined here is that of location. Location is classified as a contextual variable by Hall.[9] As Blau and Scott point out, setting can influence organizations,

whether the setting be cultural or geographical.[10] In this case, the dimension of urban-rural was selected for analysis. The hypothesis is that hospitals located in urban areas will perceive the HSA more favorably because their environment is likely to be more competitive, i.e. crowded with other hospitals. Urban environments are generally more differentiated and thus the need for coordination may be more apparent.

In the study sample, 42% of the hospitals responding were located in urban areas, while 58% were located in rural areas. The environments were perceived by the respondents themselves as either urban or rural; no definition was provided. 64% of the administrators of hospitals located in urban areas felt that the HSAs are necessary. 53% of the administrators of hospitals located in rural areas felt the HSAs are necessary.

With N's of 11 and 15 in the two categories, a statistical test of the hypothesis is probably inappropriate, nevertheless directionality should be noted.

Sociologists and others interested in the phenomenon of organizational growth and development have utilized the variables of organization size and age as a basis of investigation. As Starbuck[11] notes, "one reason growth and development evoke research interest is the possibility of uncovering characteristics which apply generally to organizations of various kinds".

The study of organizational phenomenon has been premised on the assumption that common denominators do exist among large classes of organizations. Independent variables like size or age have produced important and significant correlations. There

is a question whether these correlations are important in and of themselves, but generally one can state that at least as far as organizational size is concerned, it is only part of a more complicated picture of interconnected explanatory variables.

In this study size is operationalized on two levels. One level deals with number of persons serviced,i.e. bed capacity, the other with number of persons providing service, i.e. size of staff generally and number of physicians on the staff. The researcher's hypothesis was that due to their own increased differentiation and awareness of the need for coordination, larger hospitals, regardless of operational measure employed, would view HSAs as more necessary than smaller hospitals.

When examining hospitals according to bed capacity, we find that the larger the bed capacity of the hospital, the more necessary the administrator feels HSAs to be. Among hospitals where the administrator perceived HSAs as necessary, the mean bed capacity was 319. In cases where the response was something other than necessary, the mean bed capacity of hospitals was 125. The differences between those viewing HSAs as necessary or not grows even greater when we examine hospitals according to total number of persons on their staff. The mean number of staff in hospitals where the administrator viewed HSAs as necessary was 707, in hospitals where they felt otherwise, the mean was 300. When counting numbers of physicians on the staff we find similar trends. Hospitals where the administrator viewed the HSAs as necessary averaged 107 physicians on their staff, the other hospitals surveyed averaged 55. Thus, perception of

the necessity of the HSA does seem to be related to the size of the hospital, with administrators of larger structures being more convinced of the need.

Of all the variables examined, age of hospital, as measured by year of construction seems to be the most crucial in predicting support of the HSA. The researcher felt that newer hospitals would be more inclined to innovate generally and would probably view the HSA more favorably. His enthusiasm for this hypothesis was tempered by the realization that the newer hospitals are less urban in location, and his belief that support for the HSAs was related to location.

The crucial year of founding seemed to be 1900. Hospitals founded before 1900, which was 28% of the sample, viewed the HSAs as necessary in 86% of the cases. Hospitals founded in 1900 or after viewed the HSAs as necessary in only 44% of the cases. The researcher feels that this is related to the variable of location in that in Pennsylvania, cities are more likely than suburban or rural areas to be the home of older hospitals.

It should be pointed out that hospital prestige and effectiveness, as stated by Perrow,[12] is difficult for the layman to measure. Often times, building appearance, and other more tangible variables might be substituted. It could be that administrators of the older hospitals feel that the age of their structure makes their operation appear less adequate. They may feel that federal and other monies are going to the newer, in some cases more innovative hospitals. They may see the HSAs as possible mechanisms of fund equalization. This warrants further inquiry.

The final variable examined here is that of degree of federal funding. Federal funds have become important mechanisms for guaranteeing compliance with social change and new legislation, e.g. in areas of school busing and affirmative action. The hypothesis is that hospitals with higher rates of federal funding are more likely than those with lower rates of federal funding to view the HSAs as necessary. The mean amount of federal funding among hospitals where the administrator viewed the HSAs as necessary was 38%. Among hospitals where the administrator did not view HSAs as necessary, the mean amount of federal funding was 28%. Hospitals more dependent on federal funding for their continuance may view support of federal programs such as the HSAs as more necessary. They might perceive pressure to support the HSAs. They might also feel that their per cent of federal money could be increased through the HSAs.

It was the researcher's hunch that perception of the HSAs might be related to how administrators evaluated the HSAs relative to potential benefits for their own hospital. If, for example, the administrators viewed the HSAs as helping to increase their income from federal funds, then it was felt that they might perceive the HSAs more positively.

Administrators were asked, "how beneficial do you anticipate that a regional health coordinating group such as an HSA would be to your hospital?" They were asked to respond on a four point scale. A response of one indicated that they expected the coordinating group to be "very beneficial". A re-

sponse of two indicated that they expected the HSAs to be "somewhat beneficial", three was equated with "not too beneficial", and four with "not beneficial at all". Overall, the median response fell between "somewhat beneficial" and "not too beneficial". When responses are cross-sorted according to perception of necessity of the HSA some quite interesting results are obtained.

Among those administrators who viewed the HSAs as necessary, the modal response was that the HSAs would be somewhat beneficial. Their mean response was 2.13. Among those who responded that the HSAs were not necessary, the modal response was that the HSAs would be not too beneficial. Their mean response was 3.28. Obviously, the two groups differ in their response, with the difference being in the hypothesized direction. Exchange theory seems applicable in understanding this phenomenon.

Respondents were also queried as to how effective they expected the HSAs to be in their coordinating efforts. They were asked to respond on a four point scale similar to the scale above. The mean response was a score of 2.64, which fell between "moderately effective" and "not too effective". Again, those who viewed the HSAs as necessary had a higher mean score than those who did not. The scores were 2.0 versus 3.2 respectively.

In sum, this paper has explored issues in the perception of the HSA, a trend with future significance for the delivery of health services. A number of organizational variables have been set up to function as explanatory factors. However, replication

is needed to explore these variables in greater depth and to be able to statistically weight their significance and interconnectedness. Work is also needed on other levels. How do individuals and/or groups and communities perceive the HSAs? Of course, true appraisal of the HSA model can only come after more time is allowed for operation.

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